FH
[redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION

HMO/158809

PRELIMINARY RECITALS

Pursuant to a petition filed July 01, 2014, under Wis. Stat. § 49.45(5)(a), and Wis. Admin. Code § HA 3.03, to review a decision by the Division of Health Care Access and Accountability in regard to Medical Assistance, a hearing was held on July 29, 2014, at Milwaukee, Wisconsin.

The issue for determination is whether Petitioner's personal care worker hours have been correctly determined by the Family Care agency.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:
Petitioner:

[redacted]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, Wisconsin 53703
By: Atty. Elizabeth Bartlett
iCare
1555 N. Rivercenter Drive
Suite 206
Milwaukee, WI 53212

ADMINISTRATIVE LAW JUDGE:
David D. Fleming
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a resident of Milwaukee County. He is a Medicaid recipient receiving services through iCare.

2. Petitioner was sent a notice, dated June 23, 2014, which informed him that his personal care worker hours were being reduced to an hour per day. He had been receiving PCW assistance from about 9 AM to 10:45 AM per day after a prior authorization request was made for those benefits and pending an assessment by the agency.

3. An in-home assessment was completed on June 13, 2014 and that assessment found that Petitioner needs assistance getting in and out of the shower and with dressing his left lower extremity. Thirty (30) minutes per day was approved for showering and 10 minutes per days for dressing. An additional ¼ of that time was added for services incidental to those approved tasks and that 50 minutes was rounded up to an hour of care per day.

4. The June 13, 2014 in home assessment found that Petitioner could bathe himself once again the shower and was independent in upper body dressing. He was able to bend his arms at the elbows, raise his arms above his head and had hand grasps noted to be equal and strong. The agency has determined he was capable of doing his own grooming. He was noted to be independent as to mobility, transfers, toileting, eating and taking medications. He was observed walking with and without an assistive device though it appears that he does use a walker most often and a cane at times.

5. Petitioner is 53 years of age ([redacted]) and lives in the community. He is diagnosed with chronic pain, bilateral lower extremity edema and has a history of multiple gunshot wounds to his abdomen and left thigh. Petitioner does use a shower chair.

6. The HMO decision was reviewed by the Department of Health Services and it concurred with the iCare decision.

DISCUSSION

Under the discretion allowed by *Wis. Stat., §49.45(9)*, the Department of Health Services (DHS) requires MA recipients to participate in HMOs. *Wis. Admin. Code, § DHS 104.05(2)(a).* Medicaid recipients enrolled in HMOs must receive medical services from the HMOs' providers, except for referrals or emergencies. *Wis. Admin. Code, § DHS 104.05(3).*

When determining whether to approve any service, the HMO, as with the Department, must consider the generic prior authorization review criteria listed at *Wis. Admin. Code, § DHS 107.02(3)(e)*. The Medicaid program may only reimburse providers or medically necessary and appropriate health care services and equipment listed in *Wis. Stat. §§ 49.46(2) and 49.47(6)(a)*, as implemented by *Wis. Admin. Code, Ch. DHS 107*. Some services and equipment require submission and approval of a written prior authorization request by the provider. Some services and equipment are never covered. The criteria are as follows:

> (e) *Departmental review criteria.* In determining whether to approve or disapprove a request for prior authorization, the department shall consider:
> 1. The medical necessity of the service;
> 2. The appropriateness of the service;
> 3. The cost of the service;
> 4. The frequency of furnishing the service;
> 5. The quality and timeliness of the service;
> 6. The extent to which less expensive alternative services are available;
> 7. The effective and appropriate use of available services;
> 8. The misutilization practices of providers and recipients;
> 9. The limitations imposed by pertinent federal or state statutes, rules, regulations or interpretations, including medicare, or private insurance guidelines;
> 10. The need to ensure that there is closer professional scrutiny for care which is of unacceptable quality;
> 11. The flagrant or continuing disregard of established state and federal policies, standards, fees or procedures; and
> 12. The professional acceptability of unproven or experimental care, as determined by consultants to the department.

"Medically necessary" means a medical assistance service under ch. DHS 107 that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
(b) Meets the following standards:
1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider, and the setting in which the service is provided;
3. Is appropriate with regard to generally accepted standards of medical practice;
4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
5. Is of proven medical value or usefulness and, consistent with s. DHS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient's family, or a provider;
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.
Wis. Admin. Code, §DHS 101.03(96m).

If the enrollee disagrees with any aspect of service delivery provided or arranged by the HMO, the recipient may file a grievance with the department or appeal to the Division of Hearings and Appeals.

The HMO's determination that Petitioner should have an hour per day of PCW services is based on the factors noted at Finding #4.

Petitioner argues that the 60 minutes per day allotted for cares is not sufficient. He testified that is sometimes in such pain that he needs assistance with more than just bathing and lower extremity dressing. He indicated that he has only about 10 good days a month but is otherwise in such pain that he needs help with dressing, grooming, meals and transfers. He also stated that he needs medication reminders. Finally, he walks with his dog but needs a caregiver to accompany him.

I am sustaining the HMO determination here. The activities for which a personal care worker can provide assistance are as follows: bathing, dressing upper body, dressing lower body, placement of prosthesis, grooming, eating, mobility, toileting, transfers, medication assistance, glucometer readings, skin care, catheter site care, G-tube site care, and complex positioning. The assessment performed in his home by the HMO in June does not support assistance with any of these activities except as approved. Though Petitioner's testimony contradicts the assessment as to ADL ability, Petitioner primarily points to pain as the impediment to his self cares and even then the frequency of need is not well documented. Further, if pain causes a task to be performed more slowly this does not result in additional PCW time. *See page 2 of attachment 1 to Exhibit B*. Finally, adaptive equipment might be beneficial here. He stated that he does not have a 'grabber' that extends reach. He has a shower chair but there is no indication that he has a tall toilet or seat riser which makes transfers to and from easier for a person with a compromised thigh.

I also note that Petitioner may want to explore other programs for assistance, especially the Family Care program and the Include, Respect, I Self Direct (IRIS) program. The starting point for learning more about these programs is to contact the Milwaukee County Disability Resource Center:

How do I Contact the Disability Resource Center?
Call [redacted]
Fax [redacted]
Telecommunication Relay Service (TRS): 711
E-mail: DSD@milwcnty.com
Website: www.county.milwaukee.gov/DSD.htm

CONCLUSIONS OF LAW

That the available evidence demonstrates that the agency correctly determined that an hour of personal care worker services per day is the appropriate level services for Petitioner at this time.

THEREFORE, it is **ORDERED**

That this appeal is dismissed.

REQUEST FOR A REHEARING

This is a final administrative decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a rehearing. You may also ask for a rehearing if you have found new evidence which would change the decision. Your request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

To ask for a rehearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy of your request to the other people named in this decision as "PARTIES IN INTEREST." Your request for a rehearing must be received no later than 20 days after the date of the decision. Late requests cannot be granted.

The process for asking for a rehearing is in Wis. Stat. § 227.49. A copy of the statutes can be found at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be served and filed with the appropriate court no more than 30 days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

For purposes of appeal to circuit court, the Respondent in this matter is the Department of Health Services. After filing the appeal with the appropriate court, it must be served on the Secretary of that Department, either personally or by certified mail. The address of the Department is: 1 West Wilson Street, Room 651, Madison, Wisconsin 53703. A copy should also be sent to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for appeals to the Circuit Court is in Wis. Stat. §§ 227.52 and 227.53.

Given under my hand at the City of Milwaukee,
Wisconsin, this 18th day of September, 2014

\sDavid D. Fleming
Administrative Law Judge
Division of Hearings and Appeals

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

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The preceding decision was sent to the following parties on September 18, 2014.

iCare
Division of Health Care Access and Accountability